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	HAL018015	A. BUILDING: _____ B. WING _____	09/15/2022

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HICKORY VILLAGE	427 3RD AVENUE SE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Catawba County Department of Social Services conducted an annual survey and complaint investigations on 09/12/22 - 09/15/22 with an exit conference via telephone call on 09/15/22. The complaint investigations were initiated by the Catawba County Department of Social Services on 08/31/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents (#6 and #7) related to notifying the primary care provider (PCP) of an allegation of resident-to-resident sexual assault and obtaining a referral to appropriate mental health services after an allegation of sexual assault (#7). The findings are: 1. Review of Resident #6's current FL2 dated 05/25/22 revealed: -Diagnoses included dementia, depression, and anxiety. -The level of care was assisted living. Review of Resident #6's Resident Register revealed an admission date of 06/14/21.	D 273		

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Review of Resident #6's current Care Plan dated 04/05/22 revealed she was always disoriented with significant memory loss.

Review of a progress note for Resident #6 dated 08/07/22 revealed:
-The MA supervisor documented at 10:36pm an incident occurred on 08/07/22 at 10:30pm.
-A male resident was observed in bed with Resident #6 and her incontinence brief down around her ankles.
-Resident #6 stated the male resident pulled her incontinence brief down, had his hand inside her, and touched her breast.
-The male resident was removed from the bed and the room.
-The incident was reported to the Executive Director (ED).

Telephone interview with a personal care aide (PCA) on 09/13/22 at 10:08am revealed:
-She was working on 08/07/22.
-When she was conducting routine rounds she observed the male resident laying on Resident #6's bed on top of the covers near the foot of the bed.
-Resident #6 was also on the bed with the blankets over her.
-When she pulled the blankets down she saw that Resident #6's incontinent brief was down around her ankles.
-She asked Resident #6 if anything had happened and she said the male resident had touched her breast and was "rubbing" her.
-She notified the MA supervisor and she came to the room.
-The male resident was escorted out of the room.

Telephone interview with the hospice Registered Nurse on 09/13/22 at 9:40am revealed:

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-The ED telephoned her on 09/12/22 to inform her that on 08/07/22 Resident #6 alleged she had been sexually assaulted by another resident.
-Resident #6 was confused and oriented to person.
-Resident #6 would be able to answer questions appropriately about an event if it had just occurred.
-The resident did not have delusions or hallucinations.

Telephone interview with Resident #6's PCP on 09/13/22 at 3:58pm revealed:
-The facility did not notify him of the allegation of sexual assault immediately after the incident had occurred.
-He could not recall the date the facility notified him.
-A sexual assault exam would not have been appropriate for Resident #6 as she had advanced dementia.
-He would have expected to have been notified immediately after the incident.

Telephone interview with Resident #6's mental health provider (MHP) on 09/13/22 at 1:44pm revealed she had not been notified of any incident of a sexual nature involving Resident #6 at the facility on 08/07/22.

Based on interviews and record reviews it was determined that Resident #6 was not interviewable.

Refer to the telephone interview with the MA supervisor on 09/14/22 at 6:30am.

Refer to the interview with the Special Care Coordinator (SCC) on 09/13/22 at 11:05am and 2:50pm.

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D 273	Continued From page 3 Refer to the interview with the ED on 09/13/22 at 1:45pm and 09/15/22 at 9:30am 2. Review of Resident #7's current FL2 dated 08/19/22 revealed: -Diagnoses included dementia with behavior disturbance, hepatic encephalopathy, acute psychosis, and hyperammonemia. -Level of care was special care unit. Review of Resident #7's Resident Register revealed an admission date of 08/03/22. Review of Resident #7's Care Plan dated 08/04/22 revealed: -There was no documentation of behavioral issues. -Resident #7 was always disoriented with significant memory loss and ambulated independently with wandering. Review of the progress notes for Resident #7 dated 08/07/22 at 10:32pm revealed Resident #7 pulled down a female resident's incontinence brief and touched her in a sexual manner. Telephone interview with Resident #7's mental health provider (MHP) on 09/13/22 at 1:44pm revealed: -She was not notified of any incident of a sexual nature involving Resident #7 at the facility on 08/07/22. -She evaluated Resident #7 for the first time on 08/23/22. -Staff had informed her Resident #7 had not been sleeping and had been sexual towards female residents. -She was not provided with any specifics about any incident involving Resident #7 by staff.	D 273		

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Telephone interview with Resident #7's PCP on 09/13/22 at 3:58pm revealed:
-The facility did not notify him of the allegation of sexual assault immediately after the incident had occurred.
-He could not recall the date the facility notified him.
-He would have expected to have been notified immediately after the incident.

Interview with a personal care aide (PCA) on 09/13/22 at 3:50pm revealed:
-She had discovered Resident #7 lying on the bed of a female resident.
-Resident #7's head was near the foot of the bed and his feet near the female resident's head.
-The female resident was completely covered by her blanket.
-She told Resident #7 to get up and he did not want to get out of the bed.
-The female resident told her Resident #7 was rubbing on her and touched her breast.
-She informed the MA supervisor of what the female resident told her.
-She and the MA supervisor called the Executive Director (ED) and explained to her what had happened.
-The ED was on speaker phone and she heard the ED tell the supervisor to write the incident up and to put Resident #7 on the list for the primary care provider.

Based on interviews and record reviews it was determined that Resident #7 was not interviewable.

Attempted telephone interview with Resident #7's family member 09/13/22 at 1:10pm, 09/14/22 at 11:31am and 09/14/22 at 4:10pm was

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unsuccessful.

Refer to the telephone interview with a MA supervisor on 09/14/22 at 6:30am.

Refer to the interview with the SCC on 09/13/22 at 11:05am and 2:50pm.

Refer to the interview with the ED on 09/13/22 at 1:45pm and 09/15/22 at 9:30am.

_____

Telephone interview with a MA supervisor on 09/14/22 at 6:30am revealed:
-She was working in the facility the evening of 08/07/22.
-An alarm sounded and staff were going into rooms to find out where the alarm was coming from.
-A PCA notified her Resident #7 was in Resident #6's room laying on the bed with Resident #6.
-She went to the room and found Resident #7, fully clothed, laying at the end of Resident #6's bed with his feet hanging off the bed.
-The PCA told her Resident #6 said Resident #7 pulled her incontinence brief down and touched her breast.
-Resident #7 was escorted out of the room.
-She then checked Resident #6 for any injuries.
-Resident #6 told her Resident #7 had put his hand inside her.
-She telephoned the ED that evening (08/07/22) and informed her what had occurred.
-She documented an electronic progress note in both residents' record about the incident and shared the information with the ED.
-The ED instructed her to write Resident #7's name on the list to be seen by the facility's contracted physician during his next visit to the facility and to keep a watch on Resident #7.
-The ED had instructed her to write Resident #6's

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name on a list to be seen by the facility's contracted physician during the next visit.

Interview with the Special Care Coordinator (SCC) on 09/13/22 at 11:05am and 2:50pm revealed:
-The third shift MA supervisor had informed her the morning of 08/08/22 that Resident #7 had been found laying on the bed with Resident #6.
-Both residents were fully clothed and Resident #6's incontinent brief was on with one tab that closes the brief open.
-The MA supervisor did not say any kind of sexual assault had occurred just that Resident #7 was found in Resident #6's room.
-She made a referral to the mental health provider (MHP) for Resident #7 on 08/18/22 for the incident on 08/07/22.
-She was not aware of an allegation of sexual assault on 08/07/22 until 09/11/22 when staff informed her that a police officer was in the facility about an allegation of sexual assault.
-She did not read Resident #6's progress note dated 08/07/22 until after the police officer came to the facility on 09/11/22.
-If she had known about the sexual assault allegation on 08/07/22 she would have reached out to the ED for direction.
-She had not informed the physician because she was not aware a sexual assault had transpired based on what was reported to her by the MA supervisor on the morning of 08/08/22.

Interview with the ED on 09/13/22 at 1:45pm and 09/15/22 at 9:30am revealed:
-She had been notified the evening of 08/07/22 by the MA supervisor that Resident #7 was found in Resident #6's room in the same bed together.
-Resident #6 was covered with a blanket, she was wearing a t-shirt, and her incontinence brief

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D 273	Continued From page 7 was down around her ankles. -Resident #7 was fully clothed at the end of the bed in a fetal position. -The ED instructed the MA supervisor to keep "an eye" on Resident #7 and redirect him. -She thought Resident #7 was having wandering behaviors. -The MA supervisor had not informed her of a sexual assault allegation. -She instructed the MA supervisor to add Resident #7 to the list to be seen by the facility's contracted physician the next time he came to the facility. -She did not instruct her to add Resident #6 to the list to be seen by physician. -On 08/08/22 she read the progress note on the events of 08/07/22 in Resident #6's record. -There was no witness to the event. -She did not think a sexual assault had occurred because Resident #7 was fully clothed, Resident #6 was not in any distress when staff went into the room, and Resident #6 had pulled her own incontinence brief down in the past. -The facility policy after an allegation of sexual assault was to inform the physician and send to the emergency department for an exam if the family was in agreement. _____ The facility failed to notify the primary care provider, hospice, and the mental health provider for Resident #6 and the primary care provider and make a referral for mental health services for Resident #7 after an allegation of a sexual assault. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on September 13, 2022.	D 273		

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D 273	Continued From page 8 THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED OCTOBER 30, 2022.	D 273		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to immediately notify the local department of social services (DSS) and law enforcement for 2 of 2 sampled residents (#6 and #7) related to a resident who alleged she was sexually assaulted (#6) by another resident (#7). The findings are: Review of an Accident/Injury Report dated 09/12/22 for Resident #6 revealed: -Under the description section of no injury, 08/07/22 at 10:30pm, resident's room. -The type of incident was sexual behavior. -The resident was laying in her bed with her brief on by her lower extremities. -The resident was able to state her name and	D 453		

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answer.
-There was no documentation Resident #6 alleged Resident #7 had sexually assaulted her.
-There was no documentation that law enforcement and DSS were notified on 08/07/22.

Review of a Accident/Injury Report dated 09/12/22 for Resident #7 revealed:
-Under the description section of incident without injury on 08/07/22 at 10:30pm in another resident's room.
-The type of incident was sexual behavior.
-Resident #7 was found laying at the foot of another resident's bed.
-There was no documentation of a sexual assault allegation made against Resident #7.
-There was no documentation that law enforcement and DSS were notified on 08/07/22.

1. Review of Resident #6's current FL2 dated 05/25/22 revealed:
-Diagnoses included dementia, depression, and anxiety.
-Level of care was assisted living.

Review of Resident #6's Resident Register revealed an admission date of 06/14/21.

Review of Resident #6's current Care Plan dated 04/05/22 revealed she was always disoriented with significant memory loss.

Review of a progress note for Resident #6 dated 08/07/22 revealed:
-The medication aide (MA) supervisor documented at 10:36pm an incident occurred on 08/07/22 at 10:30pm.
-A male resident was observed in bed with Resident #6 and her incontinence brief down was around her ankles.

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-Resident #6 stated the male resident pulled her incontinence brief down, had his hand inside her and touched her breast.
-Resident #7 was removed from the bed and the room.
-The incident was reported to the Executive Director (ED).

Refer to the telephone interview with a police officer for the local law enforcement officer on 09/14/22 at 11:00am.

Refer to the telephone interview with a representative at the local police department on 09/13/22 at 2:22pm.

Refer to the telephone interview with a MA supervisor on 09/14/22 at 6:30am.

Refer to the interview with the Special Care Coordinator (SCC) on 09/13/22 at 11:05am and 2:50pm.

Refer to the interview with the ED on 09/13/22 at 1:45pm and 09/15/22 at 9:30am.

Refer to the telephone interview with the local DSS Adult Home Specialist on 09/15/22 at 10:08am.
2. Review of Resident #7's current FL2 dated 08/19/22 revealed:
-Diagnoses included dementia with behavior disturbance, hepatic encephalopathy, acute psychosis, and hyperammonemia.
-Level of care was special care unit.

Review of Resident #7's Resident Register revealed an admission date of 08/03/22.

Review of Resident #7's Care Plan dated

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D 453	Continued From page 11 08/04/22 revealed Resident #7 was always disoriented with significant memory loss and ambulated independently with wandering. Review of the progress notes for Resident #7 dated 08/07/22 at 10:32pm revealed Resident #7 was pulling down a female resident's brief and touching her in a sexual manner. Refer to the telephone interview with a local law enforcement officer on 09/14/22 at 11:00am. Refer to the telephone interview with a representative at the local police department on 09/13/22 at 2:22pm. Refer to the telephone interview with a MA supervisor on 09/14/22 at 6:30am. Refer to the interview with the Special Care Coordinator (SCC) on 09/13/22 at 11:05am and 2:50pm. Refer to the interview with the ED on 09/13/22 at 1:45pm and 09/15/22 at 9:30am. Refer to the telephone interview with the local DSS Adult Home Specialist on 09/15/22 at 10:08am. _____ Telephone interview with a local law enforcement officer on 09/14/22 at 11:00am revealed: -A former employee of the facility had contacted the local police department on 09/11/22 and stated a resident had been raped at the facility and it had not been reported. -The officer went to the facility on 09/11/22 and spoke with the ED who stated there had been no sexual assault allegation that she was aware of.	D 453		

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Telephone interview with a representative at the local police department on 09/13/22 at 2:22pm revealed there was no record of a telephone call from the facility on 08/07/22 about a sexual assault allegation.

Telephone interview with a MA supervisor on 09/14/22 at 6:30am revealed:
-She was working the evening of 08/07/22.
-The MA did not notify the police or the local department of social services (DSS) because she did not feel it was her place to do that after she had notified the ED of what had occurred.

Interview with the Special Care Coordinator (SCC) on 09/13/22 at 11:05am and 2:50pm revealed:
-She was not aware of an allegation of sexual assault until a law enforcement officer came to the facility on 09/11/22.
-If she had known she would have reached out to the ED for direction.
-She was not aware that an allegation of sexual assault required reporting to DSS.

Interview with the Executive Director (ED) on 09/13/22 at 1:45pm and 09/15/22 at 9:30am revealed:
-She had been notified the evening of 08/07/22 by the MA supervisor that Resident #7 was found in the same bed together with Resident #6 in her room.
-Resident #6's was covered with a blanket, she was wearing a t-shirt, and her incontinence brief was down around her ankles.
-Resident #7 was fully clothed at the end of the bed in a fetal position.
-She instructed the MA supervisor to keep "an eye" on Resident #7 and redirect him.
-The MA supervisor had not informed her of a

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sexual assault allegation.
-On 08/08/22 she read the progress note on the events of 08/07/22 in Resident #6's record.
-She asked the MA supervisor about the progress note and the MA supervisor informed her that what was in the progress note was correct.
-She was not aware an Accident/Incident report should have been completed on an incident involving "behaviors".
-She did not think a sexual assault occurred because Resident #7 was fully clothed, Resident #6 was not in any distress when staff went into the room, and Resident #6 had pulled her own incontinence brief down in the past.
-She had not telephoned the local police department or DSS about the alleged sexual assault incident because she believed a sexual assault had not occurred.
-The facility policy after an allegation of sexual assault was to inform the physician, notify law enforcement, and send to the emergency department for an exam if the family was in agreement.

Telephone interview with the local DSS Adult Home Specialist on 09/15/22 at 10:08am revealed she was not notified of the allegation of sexual assault on 08/07/22 until after a police officer went to the facility on 09/11/22 having received a report of a rape.

_____

The facility failed to to contact the local department of social services and law enforcement for 2 of 2 sampled residents (#6 and #7) immediately after a sexual assault allegation. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

_____

The facility provided an acceptable plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018015	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY VILLAGE	427 3RD AVENUE SE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 453	Continued From page 14 protection in accordance with G.S. 131D-34 on September 13, 2022. THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED OCTOBER 30, 2022.	D 453		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care and reporting of accidents and incidents. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents (#6 and #7) related to notifying the primary care provider (PCP) of an allegation of resident-to-resident sexual assualt and obtaining a referral to appropriate mental health services after an allegation of sexual assault (#7). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to immediately notify the local	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 15 department of social services (DSS) and law enforcement for 2 of 2 sampled residents (#6 and #7) related to a resident who alleged she was sexually assaulted (#6) by another resident (#7). [Refer to Tag 0453 10A NCAC 13F .1212 Reporting of Accidents and Incidents (Type B Violation)].	D912		